National Mental Health Association

Medicare Prescription Drug Coverage

GET EDUCATED, GET ENROLLED

A Workbook for Mental Health Consumers

TABLE OF CONTENTS

WELCOME

The National Mental Health Association (NMHA) is pleased to present this workbook to help you as a mental health consumer "get educated" about and "get enrolled" in the new Medicare prescription drug program.

For the first time, this program will help people with Medicare get medications. It will also change how people with Medicare and Medicaid (called "dual eligibles") receive their medications. After January 1, 2006, the Medicare program — not Medicaid — will pay for medications for people who are dual eligibles.

This workbook will help you to understand:

1. Who can receive the new prescription drug benefit;
2. How to enroll in a prescription drug plan;
3. How to apply for a program called *Extra Help*;
4. How to get medications; and
5. How to ask for exceptions and appeals.

To help you through the enrollment process, we have also included reminders about important dates and deadlines, a list of questions for use with doctors, case managers and pharmacists, worksheets and a glossary of terms. We encourage you to take advantage of this workbook and the resources shown below. NMHA and its 340 affiliates are ready to help you get the most out of this new program.

For more help, contact:

- National Mental Health Association (NMHA) Resource Center
  http://www.nmha.org or 1-800-969-6642.
- Your local Mental Health Association
  http://www.nmha.org/affiliates/directory/index.cfm
- Centers for Medicare and Medicaid Services
  www.medicare.gov
  1-800-MEDICARE (1-800-633-4227)
- State Health Insurance Assistance Program (SHIP)
  https://www.shiptalk.org
- Access to Benefits Coalition
  http://www.accesstobenefits.org

KNOW THE BASICS

Medicare Prescription Drug Coverage Is New

Starting January 1, 2006, the Medicare program will provide a new prescription drug benefit to all people who receive Medicare. This new program will help pay for some or all of the drug costs for people who join a drug plan.

People With Medicare Will Get Help With Medication Costs

Two groups can get the new prescription drug coverage: (1) people with Medicare and (2) people with Medicare and Medicaid (known as "dual eligibles").

This is an Insurance Program

This coverage is an insurance program, with two types of participating insurance companies: (1) private insurance prescription drug plans (PDPs) and (2) Medicare Advantage prescription drug plans (MA-PDs), which are managed care companies offering other health services and prescription drugs. You will be able to choose one plan and enroll to get coverage from that plan. Plans will decide what drugs to cover and list them on a formulary. If you are currently in a Medicare Advantage managed care plan, you will need to choose a plan linked to your managed care plan.

Dates to Know

Plan information available to public: October 15, 2005
Enrollment begins: November 15, 2005
Coverage begins: January 1, 2006
Initial enrollment deadline: May 15, 2006

Costs

Most people in a prescription drug plan will pay a monthly premium, co-payments for each medication, an annual deductible and co-insurance. People with Medicare and Medicaid and some people with limited incomes will have lower costs. The following chart outlines the basic costs of the program.

Income Levels	People with Medicare above 150% of Federal Poverty Level (FPL)	People with Medicare between 135% and 150% of FPL[1]	People with Medicare under 135% of FPL[2]	People with both Medicare and Medicaid (Dual Eligible)
Monthly Premium	About $32 per month	Sliding scale	None	None
Annual Deductible (person pays full costs of drugs until deductible is met)	$250	$50	None	None
Co-payment/Co-insurance (for drug costs up to $2,250 annually)	25% of drug costs after deductible is met	15% of drug costs after deductible is met	$2-$5 co-pays	Under 100% of FPL: $1 – $3 co-pays Above 100% of FPL: $2 – $5 co-pays
Doughnut Hole (for drug costs between $2,250 and $5,100 annually)	100% of drug costs	No costs	No costs	No costs
Catastrophic Coverage (for drug costs over $5,100)	5% or co-pays of $2-$5 (whichever is more)	Co-pays of $2-$5	No costs	No costs

How to Enroll

You will receive information about your local plan choices in October 2005. A *Medicare & You* handbook will be mailed to you from the Centers for Medicare and Medicaid Services (CMS), and you can get information in writing and on the Internet to help you find the plan that meets your needs. You need to choose a plan and can begin enrolling on November 15, 2005. People with Medicare and Medicaid will be auto-enrolled into the lowest cost plan in their area but may choose another plan before January 1, 2006.

Extra Help Program

For people with limited income and resources — including people with Medicare and Medicaid and those with income below 150% of the Federal Poverty Level — the government will pay for many of the costs of the new drug coverage through its *Extra Help* program.

Apply for *Extra Help* Now. People who fit the income guidelines should have received an application for *Extra Help* in the mail. People with Medicare and Medicaid should have received a letter informing them that they automatically get this extra help. If you did not receive a letter, call 1-800-MEDICARE (1-800-633-4227) or your local Social Security Administration office to find out if you automatically get *Extra Help* or to fill out an application.

Where to Go for More Information

For more details about the new program, see NMHA's *The New Medicare Drug Benefit: What Consumers Need to Know*. For a copy, call NMHA's Resource Center at 1-800-969-6642 or download a copy at *http://www.nmha.org/medicare*. If you have questions about what the Medicare drug benefit means for homeless individuals, individuals in long-term care facilities, or other situations, please call NMHA's Resource Center. See page 27 for additional sources of information about the new Medicare prescription drug benefit.

1 Below 150% of Federal Poverty Level (FPL) means income below $14,355 and assets below $11,500 for an individual and income below $19,245 and assets below $23,000 for a couple.
2 Below 135% of FPL means income below $12,919 and assets below $7,500 for an individual and income below $17,320 and assets below $12,000 for a couple.

TIPS FOR CONSUMERS

Talk to your doctor or case manager now. Start talking with your doctor or case manager about the Medicare prescription drug coverage now. You should talk about steps you will take to find the plan that best meets your needs and ask if you need to make any changes in your medication now to get ready for the new benefit. Use the questions on page 14 to help you.

Know your rights and responsibilities. Read the sections on enrollment (pages 8-15) and appeals (pages 18-22) for details about what you must do to get the Medicare prescription drug coverage and about how your rights are protected. People can help you join a plan, get your medications, and, if needed, ask for a plan to review a denial of coverage.

Ask for help. There are many people and groups who can answer your questions, help you apply for *Extra Help* or join a plan, and help you get your medications. See page 27 for a list of people and groups that can help you.

Keep good records. Use the pages in the back of this book to write down the date and time of any contacts you make on the phone or in person. Put *all* letters, notices, and fact sheets that the federal government, your state Medicaid office, or the prescription drug plans send you in a safe place and think about sharing important documents with your doctor or case manager.

Keep track of your true out-of-pocket costs. The government will pay all or most of the prescription drug costs during a plan year for people with limited income and resources who spend more than $3,600 in out-of-pocket costs. See the Glossary on page 23 for a list of these costs. Your Medicare prescription drug plan must keep track of your out-of-pocket costs, but you can also use the form on page 31 to track your own costs.

HOW DO I ENROLL?

All people with Medicare can choose to join a plan to get Medicare prescription drug coverage. The steps to enroll may differ if you have both Medicare and Medicaid (called "dual eligible"). The questions on this page will help guide you to the right steps for enrolling in a the prescription drug plan.

1. Determine Your Eligibility

Do you have Medicare and Medicaid? If you currently have Medicare and Medicaid benefits, you are called a dual eligible.

YES, I AM DUAL ELIGIBLE.

There are two different types of dual eligibles. Your Medicaid ID card may have this information. Check the box below that applies to you.

☐ **I am a full-benefit dual eligible.**

You are a full-benefit dual eligible if you receive your prescription drugs from Medicaid right now. Go to page 9.

☐ **I am a partial-benefit dual eligible.**

You are a partial benefit dual eligible if Medicaid pays for your Medicare premiums and maybe some other Medicare costs, but not your prescription drugs. Go to page 10.

NO, I AM NOT DUAL ELIGIBLE. Go to page 11.

I AM NOT SURE IF I'M DUAL ELIGIBLE. Contact your state's Medicaid office to find out. (Use the phone number on your Medicaid card or find the local phone number at: *http://www.cms.hhs.gov/medicaid/statemap.asp* or on the state resource sheet at *www.nmha.org/medicare*.)

2. Know the Process

Full-Benefit Dual Eligibles

(Medicaid currently pays for your prescription drugs.)

Step 1. Receive Your Notice

June 2005: You should have received a letter in the mail from the Centers for Medicare and Medicaid Services (CMS) and the Social Security Administration (SSA). This letter explained that Medicare will start paying for your prescription drugs on January 1, 2006. The letter says you are signed up for the *Extra Help* program, which will lower the costs of your medications. See page 11 for more information about *Extra Help*.

Fall 2005: You should receive a letter from your state Medicaid agency saying that your Medicaid prescription drug coverage will end on January 1, 2006 and that the Medicare program will automatically enroll you in a Medicare plan. You may choose to enroll in a different plan.

If you do not receive these letters, call 1-800-MEDICARE (1-800-633-4227) to get this information.

Step 2. Compare Plans

October 2005: You should receive materials from CMS, including the *Medicare & You* handbook, and from plans approved by CMS in your area. CMS also will have an online tool to compare plans in your area at *www.Medicare.gov*.

October-November 2005: You should receive a letter from CMS with the name of the Medicare prescription drug plan that you will be enrolled in unless you choose another plan that better meets your needs. You should read through the plan materials, compare the coverage with other plans, and decide if you'll keep the plan or switch to another one. (See the "Tips for Comparing and Choosing a Plan" section, page 14, for more information.)

Step 3. Keep or Switch Plans

If you find a Medicare prescription drug plan that better meets your needs, you can switch to that plan before January 1, 2006. Tell the plan you want to join that you are switching, and also tell CMS after you join the plan you choose.

January 1, 2006: Your new Medicare prescription drug coverage begins and your Medicaid drug coverage ends. If you find a plan that better meets your needs, you can change to a new plan once a month.

Partial-Benefit Dual Eligibles

(Medicaid pays your Medicare premiums or other costs, but not your prescription drug costs.)

Step 1. Receive Your Notice

June 2005: You should have received a letter from the Social Security Administration about the *Extra Help* program. The letter says you are signed up for the *Extra Help* program, which lowers the costs of your medications.

If you did not receive this letter, call 1-800-MEDICARE (1-800-633-4227) to get this information.

Step 2. Compare Plans

October 2005: You should receive a *Medicare & You* handbook and materials about all the Medicare prescription drug plans available in your area. CMS also will have an online tool to compare plans in your area at *www.Medicare.gov*. See the "Tips for Comparing and Choosing a Plan" section on page 14 to help you review and compare plans and choose the one that best meets all of your medication needs. Talk with your doctor, pharmacist, case manager or other support person to help you choose a plan and to find other sources of help.

Step 3. Choose the Plan That Best Meets Your Needs

Once you choose a plan, you will need to complete and submit that plan's application. You will receive a confirmation letter and later, a membership card that you can use at the pharmacy to show your enrollment in a plan. If you find a plan that better meets your needs, you may switch plans once a month.

November 15, 2005: This is the first day you can join a Medicare prescription drug plan.

January 1, 2006: The program starts if you signed up by December 31, 2005. If you sign up after December 31, the plan will start the month after you sign up.

May 15, 2006: This is the deadline to choose and sign up for a plan. If you do not join a plan before this date, Medicare will select a plan for you.

People with Medicare Only

(You do not get Medicaid coverage.)

Step 1. Apply for *Extra Help*

August 2005: If you have a limited income, you should receive a letter and application from the Social Security Administration about the *Extra Help* program by this month. People with limited incomes and resources will have most or all of their prescription drug costs paid for by the government. See pages 12-14 for steps to apply for *Extra Help*.

Call 1-800-MEDICARE (1-800-633-4227) or your local Social Security Administration office to find out if you automatically get the *Extra Help* or to fill out an application.

Limited income means less than or equal to 150 percent of the Federal Poverty Level (FPL).

150 percent of FPL means income of $14,355 (for an individual) or $19,245 (for a couple) in 2005.

Assets or other resources (including your savings and stocks, but not counting your home) must be no more than $11,500 for individuals and $23,000 for couples (includes $1,500 burial fund per person).

Step 2. Compare Plans

October 2005: You should receive a *Medicare & You* handbook and materials about all the Medicare prescription drug plans available in your area. CMS also will have an online tool to compare plans in your area at *www.medicare.gov*. See the "Tips for Comparing and Choosing a Plan" section on page 14 to help you review and compare plans and choose the one that best meets all of your medication

needs. Talk with your doctor, pharmacist, case manager or other support person to help you choose a plan and to find other sources of help.

Step 3. Choose the Plan That Best Meets Your Needs

Once you choose a plan, you will need to complete and submit that plan's application. You will receive a confirmation letter and, later, a membership card that you can use at the pharmacy to show your enrollment in a plan. Remember that if you find a plan that better meets your needs, you may switch plans only during the open enrollment period each year.

November 15, 2005: This is the first day you can join a Medicare prescription drug plan.

January 1, 2006: The program starts if you signed up by December 31, 2005. If you sign up after December 31, the plan will start the month after you sign up.

May 15, 2006: This is the deadline to choose and join a prescription drug plan. If you do not join before this date, and you have no other source of creditable coverage, you will not be able to join a Medicare prescription drug plan without paying a premium that includes a penalty.

3. Apply for *Extra Help*

Dual Eligibles do not need to apply for *Extra Help*.

Extra Help is a program that helps eligible people pay for some or most of their prescription drug costs. If you qualify for *Extra Help*, you will not receive money; instead, Medicare will pay for part, or in some cases, all of your drug costs.

Can you get *Extra Help*?

YES - if:

- you are a full-benefit dual eligible;
- you are a partial-benefit dual eligible; or
- you do not have Medicaid coverage, but do receive Supplemental Security Income (SSI).

If you said "yes" to any of these options, you will automatically receive *Extra Help*. You do not need to apply. But, make sure you received the letter from the Social Security Administration (SSA) telling you that you will receive *Extra Help*. If you didn't receive it, call the SSA at 1-800-772-1213 or go to *http://www.socialsecurity.gov* to get another letter or to apply for the program.

MAYBE - if:

- you have a limited income. Apply to see if you are eligible. Here are some steps to help through the application process for *Extra Help*.

Step 1. Get the Application Form

By August 2005, you should receive a form to apply for *Extra Help* from the Social Security Administration (SSA). *It is very important that you fill out this application and return it to the SSA.* If you do not get this form in the mail and think you may qualify for this help, call the SSA at 1-800-772-1213 or go to *http://socialsecurity.gov* for help. SSA's application process gives you the quickest response. You can also apply at your state Medicaid office. Your Medicaid agency will also screen you for other government assistance programs that might be available to you.

Step 2. Gather Your Bank Statements

To fill out the *Extra Help* application, you will first need to have statements about your income and other sources of money (this does not include your home). You can find this information in your bank statements, investment statements, life insurance policy statements, stock certificates, tax returns, and pension award letters.

You will need to have numbers for your earned and unearned income:

Earned Income — includes wages and net earnings from self-employment.

Unearned Income — includes social security and veteran's benefits, worker's compensation, unemployment insurance benefits, railroad retirement, pensions, annuities, rent payments received, death benefits, alimony or support payments, in-kind support, and maintenance.

Also, you will also need to know information about certain kinds of assets (also called resources):

Countable Assets — these are resources that can be turned into cash within 20 days, including money in bank accounts, stocks, bonds, savings bonds, mutual funds, retirement accounts, cash, cash value of life insurance policies, and equity value of real estate (not including your home).

You can use the worksheet on page 29 to practice before filling out the *Extra Help* form.

Step 3. Fill Out and Submit the Application

Follow the directions closely on the form and submit it to the Social Security Administration or your state Medicaid office. You may also submit the application online at *www.socialsecurity.gov*. If you need help, go to your local Medicaid office or your local State Health Insurance Assistance Program (SHIP). (See page 28 for contact information.)

If you submit an incomplete application, the Social Security Administration will call you to get the missing information. If you do not want to give personal information over the phone, find out what information is needed to complete your application and call the SSA at 1-800-772-1213.

Step 4. Get the Decision

You should receive a decision letter from the Social Security Administration or your state Medicaid agency telling you if you will get *Extra Help* with your drug plan costs. Keep a copy for your records. If the government decides that you do not qualify for the *Extra Help*, but you believe that you do, you may appeal and ask the government to review the decision. Follow the directions in the letter they send you to file an appeal.

4. Tips for Comparing and Choosing a Plan

After you receive information from CMS about the plans available in your area in October 2005, read the materials and compare the benefits and costs of each plan. You may also use the tool that CMS developed to compare plans at *www.medicare.gov*. Be sure to discuss all the options with your doctor, case manager, and/or family members to help you find the plan that best meets your medication needs.

Step 1. Compare Plans

Look carefully at what medications each plan covers and what each medication will cost you. Use the medication worksheet on page 30 to record all your current medications so that you have it ready when you compare plans. To help you decide on a plan, Medicare will also offer in October 2005 *A Plan Comparison Web Tool* and *Medicare Personal Plan Finder* at *http://www.medicare.gov*.

Here are some important questions to ask as you review the plans in your area:

1. Which of my medications are covered on the plan formulary (list of covered drugs)?
    a. Is the dosage I need covered?
2. Which of my medications are not covered?
3. Does my doctor need to get prior authorization to prescribe any of my medications?
    a. If yes, which ones?
4. Does the plan require me to try a different medication before I can receive a medication I'm currently prescribed (called "step therapy")?
    a. If yes, for which medications?
5. What information does my doctor need to provide to get approval for my medication to be covered (also known as an exception)?
6. Does the plan provide me with my medication during this exception process?
7. How much is the premium for the plan(s) offered in my area?
8. How much are the co-payments for each prescription?
9. In addition to co-payments, am I required to pay part of the cost of my medications?
10. Is my pharmacy in the plan network?

Note to Dual Eligible Individuals: The *Extra Help* program will cover the premium for the lowest-cost plan in your region. If you choose a higher cost plan, you will have to pay the difference between the premium cost covered by *Extra Help* and the actual premium cost of the plan you choose.

Step 2. Join a Plan

Once you find a plan that best meets your needs, fill out an application for that plan (this application may be a paper form or on the Internet). Be sure to follow the directions on the application. After your application has been received and processed, you will receive a letter and a membership card from the plan.

Step 3. Switch Plans

Full-Benefit Dual Eligibles Only: For those individuals with Medicare and Medicaid who are automatically enrolled in a plan, you may switch to another plan that better meets your needs before January 1, 2006. If you decide to switch plans:

- Contact CMS about your desire to switch to another plan. Contact information should be in the letter you received with the name of your plan, or call 1-800-MEDICARE (1-800-633-4227).
- Call the plan into which you were enrolled about your decision to switch.
- Contact the new plan you chose and get enrollment materials.
- Keep copies of all plan letters, notices, and brochures and also give your doctor your Medicare prescription drug plan information.
- You may switch to a plan that better meets your needs once each month after the prescription drug coverage starts on January 1, 2006.

Partial-Benefit Dual Eligibles: You may switch to a plan that better meets your needs once each month after the prescription drug coverage starts on January 1, 2006. In order to switch plans, follow the steps listed above.

People with Medicare Only: You may switch to a plan that better meets your needs only during the annual enrollment period (November 15-January 1). Special enrollment periods will apply for some situations, including changes of address, for individuals in institutions, and for changes in eligibility for Medicare. See the Glossary on pages 23-26 for more information about special enrollment periods.

GETTING YOUR MEDICATIONS

Once you join a prescription drug plan, follow these steps to get your new or refill prescriptions filled:

Step 1. Find Your Pharmacy

Find your **network pharmacy (or pharmacies)** listed on your plan materials or call the plan customer service line. Note: record this number on page 33 for future use. Make sure the pharmacy you use now is part of the network for the prescription drug plan you joined.

Step 2. Fill Your Prescription

Ask your doctor to call your prescription in and check that the medication is covered by your plan or bring in a paper prescription to the **network pharmacy**. Remember to bring your Medicare prescription drug plan card with you. If you do not have your card, you can give the pharmacist your Medicaid participant number or your Social Security number to check which plan you are enrolled in.

- If the pharmacy tells you that your medication is NOT covered, call your plan to ask them if the medication is not covered.
- Call your doctor or case manager to let them know.
- Discuss if you should seek an exception or change your medication. See the steps on **exceptions** and **appeals** in the "Know Your Rights" section of this workbook.

Step 3. Pay Your Required Cost-Sharing Amounts

You may have to pay a small fee (known as a **co-payment** or **co-pay**) when you pick up your prescription at the pharmacy. If you cannot afford the co-payment, ask your pharmacist if he or she can waive the amount. The government has said pharmacists can decide whether to require payment from you or fill your prescription drugs without the co-payment.

Other cost-sharing requirements may include **co-insurance**, which is a percentage of the cost of the prescription drug. Individuals with Medicare and Medicaid will not be required to make co-insurance payments.

If you cannot afford the cost-sharing requirements of your plan, there may be a state program to help cover your costs — contact your local State Health Insurance Assistance Program (SHIP) or the Partnership for Prescription Assistance to find out if such a program exists. See page 28 for contact information.

Step 4. Keep Track of Your True Out-of-Pocket Costs

It is important to keep track of your **out-of-pocket costs** because, depending on your income level, the government will pay for most (or in some cases, all) of your prescription drug costs for the rest of the plan year, once you pay $3,600 in out-of-pocket costs. These costs do not include premium payments, but do include *all* prescription drug costs paid by you or another organization, including the federal government (e.g., *Extra Help*), State Pharmacy Assistance Programs (SPAPs), or private foundations or pharmaceutical manufacturer programs.

KNOW YOUR RIGHTS: EXCEPTIONS AND APPEALS

If your new pharmacy tells you that a medication is not covered by your plan, or your plan requires a higher co-payment for your medication than for other similar medications, you have the right to have that decision reviewed and possibly changed.

These steps will help you ask for this review and get the medications you need. Use the worksheet on page 34 to keep track of all contacts you make (name of the person, phone number, and date and time of the call).

What is a Coverage Determination?
A coverage determination is a written letter from your plan telling you that it will not cover a drug.

What is an Exception?
An exception is a formal decision by your plan to cover your medication or reduce your co-payment. If an exception is granted, it will for last one year from the date of the decision and will then need to be requested again.

What is an Appeal?
If the plan does not grant the exception, you may take your case to another decision maker. This is known as an appeal.

Step 1. Check Your Plan

Call your plan hotline to find out if your medication is or is not covered. You can find your plan's phone number either in your plan enrollment materials or on your Medicare prescription drug card. *If your medication is not covered, ask for a one-time supply of your medication(s) to help you while you request an exception. Plans approved by CMS will offer at least a 30-day supply called a "transition supply" or "emergency supply."* Your plan should then send you a **coverage determination** in writing.

Step 2. Tell Your Doctor or Case Manager

Call your doctor's office or your case manager to tell them of the denial. They need to be prepared to help you.

Step 3. Think About Your Options

You should talk with your doctor to either switch your medication to one that is covered by your plan or to request that the plan cover your medication (called an **exception**). If you have both Medicare and Medicaid, you may also want to look at other plans offered in your area to see if a different plan better meets your needs.

Step 4. Ask for an Exception

Ask your doctor or a family member to help you ask for an exception. Your doctor will have to show why this medication is needed (called "medical necessity") for your plan to grant your request. See your Medicare prescription drug plan documents for forms and phone numbers that you might need for this process. Save copies of these forms with times and dates, and give a copy to your doctor or case manager for your file.

After your plan receives your request and supporting statement from your doctor, the plan must make a decision about your request within 72 hours (or 24 hours in an emergency). If you get an **exception**, go to the pharmacy to have your prescription filled. The exception will last for one year from the date it is approved.

If your exception request is denied, you can **appeal**.

There are five levels of the appeal process. The details of each level are provided on the next page of this workbook. Here are some basic tips to help you during this process:

- *Make sure you can get your medication while you appeal.* Ask for a transition supply from your plan or find state-funded or other sources at the Partnership for Prescription Assistance (*www.pparx.org* or 1-888-477-2669).
- *Ask for help from your doctor or case manager.* Your doctor will need to provide the reasons you need the medication in writing.
- *Follow the steps that your plan requires.* Look at your plan materials to give you forms, phone numbers, and other important information about how to file your request.
- *Keep track of your documents.* Use the log on page 34 of this workbook to write down the dates and times of your calls and whom you contacted. Keep copies of all letters, forms, and supporting documents that you give to your plan.
- *Report any problems.* If you have difficulty with this process or you think the plan is not reviewing your request properly, you may call several organizations to report your concerns and get additional help:
  - Centers for Medicare and Medicaid Services (CMS) — 1-800-MEDICARE (1-800-633-4227);
  - National Mental Health Association (NMHA) — 1-800-969-6642;
  - State or local ombudsman offices; and/or
  - Protection and Advocacy organizations

  See pages 27-28 for contact information for these organizations. For information about other organizations in your state, request a *State Resources* sheet from NMHA or visit *www.nmha.org/medicare*.

Appeal #1: Ask for Redetermination

Ask your Medicare prescription drug plan to review your request to get your medication again (called a **redetermination**). Your plan materials will tell you if this can be done either in writing or over the phone and what kind of information they need from you or your doctor to make a decision. Keep copies of all the documents or, if you requested the redetermination over the phone, write down the date and time you made the request and who you spoke with.

Your Medicare prescription drug plan must notify you of a decision within seven calendar days (or 72 hours in an emergency) from the time it receives all your information. If you get a redetermination in your favor, fill your prescription. It will last for one year from the date of the plan's decision.

If your redetermination is denied or the plan does not respond by the deadline, file for appeal #2, also known as **reconsideration**.

Appeal #2: Ask for Reconsideration

At this level, you will ask an **Independent Review Entity (IRE)** to review your plan's previous decision. An IRE is a regional organization under contract with prescription drug plans to review their decisions and make sure that the plans have followed processes and reviewed the details of your request properly. Your request to the IRE may be filed either in writing or over the phone.

- The IRE must get your doctor's views in writing, on the phone, or at a teleconference.
- If your plan does not meet the deadlines for making a decision on your exception or redetermination request, the plan must automatically forward your request to the IRE within 24 hours.
- The IRE must let you know of their decision within seven calendar days (or 72 hours in an emergency).

If the IRE decides in your favor, go to the pharmacy and fill your prescription. The decision to cover your medication will last for one year from the date of the decision.

If the reconsideration is denied, you may file appeal #3 — a request for an administrative law hearing.

Important Note: If your requests for your plan to cover a medication have been denied through the first two reviews, you should talk to your doctor before making another request (going to appeal levels #3-5). The time to get a decision on further appeal requests is much longer and plans are not required to give you refills of your medication during these later levels of appeals. Talk with your doctor about other medications that might work for you, or find other ways to get your medication, such as charitable organizations, drug manufacturer programs, or state-funded programs. The Partnership for Prescription Assistance can help you find programs to help you (*www.pparx.org* or 1-888-477-2669).

Appeal #3: Ask for an Administrative Law Judge (ALJ) Hearing

If the IRE denies your reconsideration request, you may ask for review by an Administrative Law Judge (ALJ), a federal government employee who will review your case to make sure the plan has followed proper processes and has reviewed your case in a way that meets federal legal requirements. To receive a hearing, your medication costs must be at least $100 (including all refills). This amount will increase yearly.

An ALJ has 90 calendar days to grant a hearing request *and* 90 calendar days to make a decision.

If the ALJ decides in your favor, fill your prescription at your network pharmacy. The decision to cover your medication will last one year from the date of this decision.

If your request is denied, then go to appeal #4 — the **Medicare Appeals Council**.

Legal Help

You are able to get legal help with the hearing process during appeal levels 3-5. To find legal help in your area, use the resources listed below. Look for legal aid organizations, health disability law organizations, or law firms that focus on Medicare:

- The American Bar Association website for free legal services: *http://www.abanet.org/legalservices/findlegalhelp/freehelp.shtml*
- If you are over 60 years old, you may find legal help here: *http://www.aoa.gov/eldfam/Elder_Rights/Legal_Assistance/Legal_Hotline.asp*
- Contact NMHA's Resource Center for information about community legal assistance at 1-800-969-6642.

Appeal #4: Ask for Review by the Medicare Appeals Council

If the ALJ does not approve your request, you may file an appeal with the Medicare Appeals Council, part of the Centers for Medicare and Medicaid Services (CMS). You may have legal help with this review.

The Medicare Appeals Council has 90 calendar days to decide a case. If the Medicare Appeals Council decides in your favor, fill your prescription. It will last one year.

If not, go to the final level of appeal — federal court.

Appeal #5: Ask for Review by Federal Court

If the Medicare Appeals Council denies your request, you may appeal to federal court. This step is also known as "Judicial Review." A lawyer may help you. To appeal at this stage, your total costs must be at least $1,050 in 2006. (This amount will increase yearly.)

If all your appeals are denied, you should:

- Contact your doctor or case manager to talk about other medication options.
- Contact the Partnership for Prescription Assistance or your local State Health Insurance Assistance Programs (SHIP). There may be a program to help you pay for your drugs. See page 28 for contact information.

GLOSSARY

Administrative Law Judge (ALJ) — An ALJ a government employee who is the decision maker at a hearing during the third step of the appeals process.

Appeal — If a person is not happy with a plan's decision about covering medication (called a coverage determination), they may ask that the decision be reviewed again. The appeal levels are: (1) Redetermination, (2) Reconsideration, (3) ALJ hearing, (4) Medicare Appeals Council, and (5) Federal Court (also known as "judicial review"). See pages 18-22 for more information.

Beneficiary — Someone who has Medicare prescription drug coverage. (Also see dual eligible.)

Centers for Medicare and Medicaid Services (CMS) — CMS is the federal government agency that administers Medicare, Medicaid, and the Medicare Prescription Drug Benefit program.

Co-insurance — A percentage of the cost of the prescription drug. For example, a 10% co-insurance on a $50 prescription would cost $5.

Co-payment — A dollar amount that a person must pay out-of-pocket for a medication or other health service. For example, a plan may ask for a $3 co-payment for each prescription.

Cost-sharing — The out-of-pocket payment a person makes to his or her cost of care. This includes deductibles, premiums, co-insurance, and co-payments.

Coverage determination — A written notice from your Medicare prescription drug plan informing you that they will or will not cover your medication.

Creditable Coverage — Drug coverage that is at least as good as the new Medicare drug benefit. If you have creditable coverage (also known as comparable coverage) you can enroll into a Medicare prescription drug plan with no penalty after May 15, 2006. Creditable coverage includes coverage from former or current employers, Veteran's, military or federal benefits, or private individual insurance.

Deductible — A flat dollar amount a person must pay before Medicare will pay for your prescription drugs costs.

Dual eligible — A person who is eligible for both Medicare and Medicaid.

Exception — A formal decision by your Medicare prescription drug plan to cover your medication or reduce your co-payment. If the plan does not approve the exception, the person can ask for a review of the plan's decision (an appeal).

Extra Help — A government benefit to help pay for part or all of the Medicare prescription drug premiums for all Medicare beneficiaries who are below 135 percent of the federal poverty level (FPL) (including dual eligibles) and part of the premium for those between 135 and 150 percent of the FPL. The benefit will also exempt beneficiaries under 150 percent of the FPL from the gap in coverage referred to as the "doughnut hole." Dual eligibles will get this benefit without applying. All others will need to apply for *Extra Help*. See pages 12-14 for details.

Formulary — A list of medications that beneficiaries may receive through their prescription drug plan (prior authorization by the Medicare prescription drug plan may be required). Medications not on the formulary are drugs that a plan will not pay for. Plans may cover a medication but may not cover all dosages and delivery (e.g., extended release forms).

Independent Review Entity (IRE) — In the second stage of the appeals process, an IRE will review a plan's decision not to cover a medication. An IRE is a review body that is under contract with the prescription drug plan to do such reviews. See page 21 for more information.

Limited income — Under Medicare, limited income means someone who is below 150 percent of the FPL. In 2005, this is equivalent to a yearly income of $14,355 for an individual and $19,245 for a couple, with other resources of $11,500 for an individual and $23,000 for a couple.

Medicare Advantage Prescription Drug Plan (MA-PD) — A managed care plan that gives beneficiaries prescription drugs and other health services. Some people in Medicare will be able to get medications through these plans beginning January 1, 2006.

Medicare Appeals Council (MAC) — The fourth stage of the Medicare prescription drug benefit appeals process is conducted by the Medicare Appeals Council (part of the Centers of Medicare and Medicaid Services), after an Administrative Law Judge (ALJ) has denied a request to cover a medication.

Medicare prescription drug coverage — The new prescription drug benefit added to the federal Medicare program, sometimes called Part D. The prescription drug coverage will begin on January 1, 2006. If you currently have Medicare and Medicaid, this new coverage will replace your Medicaid prescription drug coverage.

Network pharmacy — A pharmacy that is under contract with a Medicare prescription drug plan. Plan members must get their prescriptions filled at a network pharmacy.

Non-Medicare prescription drugs — By law, Medicare cannot cover certain drugs, including benzodiazepines, barbiturates, and prescription vitamins. Your state may have a program to cover these medications. See page 27 for resources.

Premium — Regular monthly payments made to a health plan by beneficiaries for health care coverage. The national average premium for a Medicare prescription drug plan is about $32 in 2006.

Prescription Drug Plan (PDP or Medicare prescription drug plan) — A private insurance plan that offers coverage for prescription drugs under Medicare.

Redetermination — The first stage of the appeals process after a coverage determination has been made and the Medicare prescription drug plan has decided not to cover a beneficiary's medication.

Reconsideration — The second stage of the appeals process after a redetermination has been denied. This stage of the appeals process is conducted by an Independent Review Entity (IRE).

Social Security Administration (SSA) — The federal government agency that administers and enrolls Medicare beneficiaries into the *Extra Help* program.

Special Enrollment Period (SEP) — A special provision in the Medicare drug benefit program that allows individuals to change prescription drug plans for certain reasons, such as moving out of the prescription drug plan's service area and changes in eligibility for Medicare. Dual eligibles also have a SEP allowing them to change prescription drug plans up to once a month.

True Out-of-Pocket Costs (TrOOP) — The government will pay most (or in some cases, all) of your drug costs for the rest of the year, once you pay $3,600 in out-of-pocket expenses (this amount may increase on a yearly basis). These costs do not include premium payments. Out-of-pocket costs include all prescription drug costs paid by you or another person or organization, including the government (for example, *Extra Help*), State Pharmaceutical Assistance Programs (SPAPs), registered charities, and pharmaceutical manufacturer patient assistance programs. The out-of-pocket costs include payment of the deductible, co-insurance, co-payments, and medication costs that are not covered by other insurance. These costs do not include expenses paid by the individual with Medicare prescription drug coverage for medications that are not on a plan's covered list of drugs or for medications excluded from the Medicare prescription drug benefit.

RESOURCES

For more information, contact:

National Mental Health Association Resource Center
1-800-969-6642 or *http://www.nmha.org*
See *www.nmha.org/medicare* for *State Resource* sheets that identify organizations in your state.

Local Mental Health Associations
http://www.nmha.org/affiliates/directory/index.cfm

Medicare Program
1-800-MEDICARE (1-800-633-4227) or
http://www.medicare.gov

State Medicaid Agencies
http://www.cms.gov/medicaid/statemap.asp

Local Social Security Administration Offices
http://s3abaca.ssa.gov/pro/fol/fol-home.html

State Health Insurance Assistance Programs (SHIPs)
http://www.shiptalk.org

Partnership for Prescription Assistance
http://www.pparx.org or 1-888-477-2669

Access to Benefits Coalition
http://www.accesstobenefits.org

State Ombudsman Offices
http://www.ltcombudsman.org/static_pages/ombudsmen.cfm

Medicare Rights Center
http://www.medicarerights.org

Protection and Advocacy Organizations
http://www.napas.org

WORKSHEET 1: Counting Your Income and Savings for *Extra Help*

To help you figure out if you can get assistance through the *Extra Help* program, use this worksheet to gather your income information. First, gather any pay stubs, bank statements, investment statements, life insurance policy statements, stock certificates, tax returns, and pension award letters you may have. Filling in this worksheet will help you fill out the *Extra Help* application.

Earned Income

Wages _____
Net Earnings from Self-employment _____

Unearned Income

Social Security and Veterans benefits _____
Worker's Compensation and Unemployment _____
Insurance Benefits _____
Railroad Retirement Pensions _____
Annuities _____
Rent Payments Received _____
Death Benefits _____
Alimony or Support Payments _____
In-kind Support and Maintenance _____

Countable Assets

(Resources that can be easily turned into cash within 20 days)

Money in Bank Accounts _____
Stocks _____
Bonds _____
Savings Bonds _____
Mutual Funds _____
Retirement Accounts _____
Cash _____
Cash Value of Life Insurance Policies _____
Equity Value of Real Estate _____
(does not include your home)

WORKSHEET 2: Medication List

List all your medications including what doctor prescribes the drug, how much you take and how many times each day, and any out-of-pocket costs that you pay, such as a co-payment.

Medication	Prescriber	Dosage	Number of Doses/Day	Cost

Use this list to review plan information for the prescription drug plans offered in your area. In October, you will be mailed this information. You can also use a new tool from the Centers for Medicare and Medicaid (CMS), the Plan Finder, at *www.medicare.gov*. Ask for help from your doctor, case manager, pharmacist, family member, or other supporter to read these materials.

The questions on page 14 will help you choose the plan that best meets your needs for the medications you listed here.

WORKSHEET 3: Keeping Track of Your Out-of-Pocket Costs

Once you sign up for a prescription drug plan, use this worksheet to keep track of all your out-of-pocket costs. Your drug plan will keep track of your out-of-pocket expenses, but you may also want to keep track of this amount. The government will pay most (or in some cases, all) of your drug costs for the rest of the year, once you pay $3,600 in out-of-pocket expenses (this amount may increase on a yearly basis). These costs do not include premium payments. Out-of-pocket costs include all prescription drug costs paid by you or another person or organization, including the government (for example, *Extra Help*), State Pharmaceutical Assistance Programs (SPAPs), registered charities, and pharmaceutical manufacturer patient assistance programs. Go to the Glossary on page 26 to see a list of costs that count toward your "true out-of-pocket costs." In addition, you may keep receipts or other documents of your costs in the back pocket of this workbook.

Date	Amount	Description of Cost	Medication	Pharmacy/Doctor

WORKSHEET 4: Important Information

This page will help keep important names and phone numbers in one place so you can find them quickly when you need them. Gather names and phone numbers for the people and organizations involved in your health care now. Also write down new information about your Medicare prescription drug plan and network pharmacy.

1. Health Care Providers. List the names and numbers for all of your doctors, case managers, pharmacists, or others who are involved in your care.

Name	Phone Number(s)	Condition Being Treated

2. Current Health and Prescription Drug Coverage. List the insurance or managed care plan, Medicaid agency, and/or pharmacy that provides your prescription drugs now.

Organization	Contact Person	Phone Number(s)

3. Medicare Prescription Drug Coverage. List the plan and network pharmacy names and important contact information.

Plan Name:

Customer Service Phone Number:
Prior Authorization Phone Number:
Exception/Appeal Phone Number:

Name of Network Pharmacy	Pharmacist Name	Phone Number

4. Local Organizations to Help You. For example, this can include state ombudsman offices, consumer rights organizations, community organizations, and legal groups.

Organization Name	Contact Person	Phone Number

WORKSHEET 5: Notes

Use this page to keep a record of who you talk to, when, and about what.

Date	Name/Organization	Phone No.	Subject

Use this page to keep a record of who you talk to, when, and about what.

Date	Name/Organization	Phone No.	Subject

Use this page to keep a record of who you talk to, when, and about what.

Date	Name/Organization	Phone No.	Subject

2001 N. Beauregard Street
12th Floor
Alexandria, VA 22311
(800) 969-NMHA (6642)
www.nmha.org